Provider Connection

THIRD QUARTER 2019

In this issue

Physicians Health Plan

Working with PHP

General Training 101

The Provider Relations Team offers training sessions throughout the year to help you and your office staff work smoothly with PHP.

Learning opportunities include a review of the Provider manual, checking eligibility and benefits, claim status, authorizations/approvals, and much more. Attendees should include management and all office staff.

Jan. 14, 2020 | 8:30–10 a.m.
April 16, 2020 | noon to 1:30 p.m.
July 14, 2020 | 8:30–10 a.m.
Oct. 15, 2020 | noon to 1:30 p.m.

Please email your RSVP at least one week prior to the event. All trainings take place at PHP, are free of charge, and include a light meal.

Questions? Contact **PHPProviderRelations@phpmm.org**.

Flu, Pneumonia, and Shingles Vaccinations

PHP Members with a PHP outpatient prescription drug benefit can go to any Network Pharmacy for their pneumonia vaccine, shingles vaccine*, or annual flu vaccine. The pharmacy must be able to administer the medication on-site. Pharmacies are reimbursed for the vaccine and the administration fee.

**Shingles vaccine is only covered for Members 50 years of age and older.*

Flu Vaccine Facts

- Why should Patients get vaccinated?
  - Receiving an annual flu vaccine is the best way to help protect yourself and others against the flu. By vaccinating against the flu, it has shown to have many benefits including, but not limited to, reducing the risk of flu illnesses, hospitalizations, and even the risk of flu-related death in children.
- When should Patients get vaccinated?
  - The CDC recommends that people get a flu vaccine by the end of October every year. If the October window is missed, the CDC states that it is still beneficial to get vaccinated throughout the flu season, which could continue into January or later.
- Where can Patients get vaccinated if they are unable to receive the vaccine in your office?
  - Flu vaccines are offered in most doctor's offices, health departments, pharmacies, and even some urgent care centers.

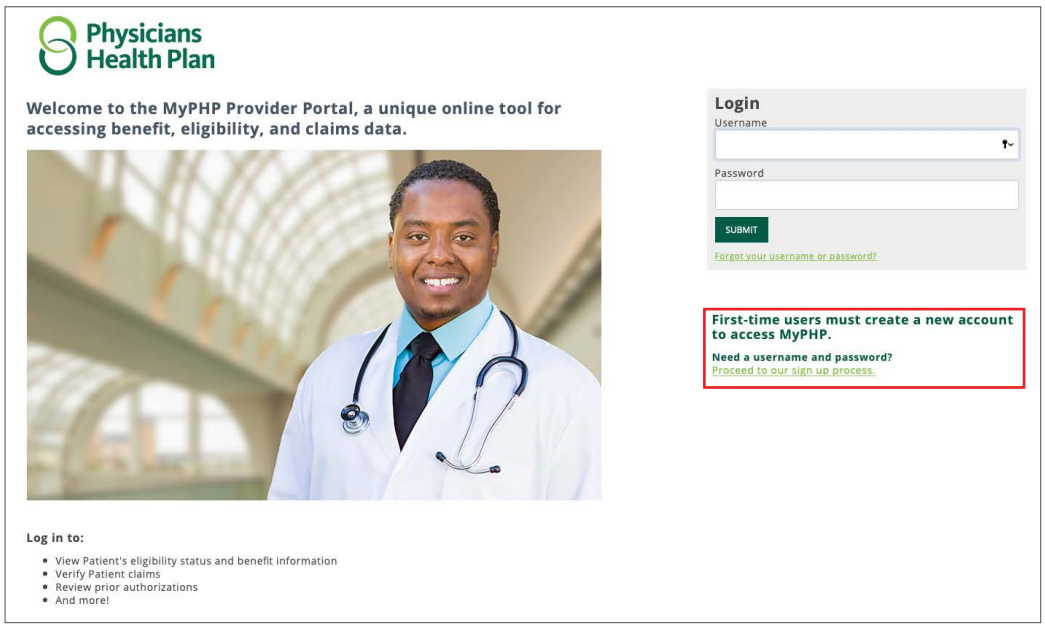
*"Key Facts About Seasonal Flu Vaccine | CDC." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, **CDC.gov/Flu/Prevent/KeyFacts.htm#Benefits**.

The form only lists 4 vaccines that are covered via pharmacy. We added several vaccines effective 10/1/18. Please see the flyer on the website at **PHPmichigan.com/Providers** and click on the pharmacy tab.

The Provider Portal is your #1 tool

There are many helpful links inside our MyPHP Provider Portal. Some of these helpful links include the Provider Manual, Provider Directory, the PHP Formulary, general forms, and an information page.

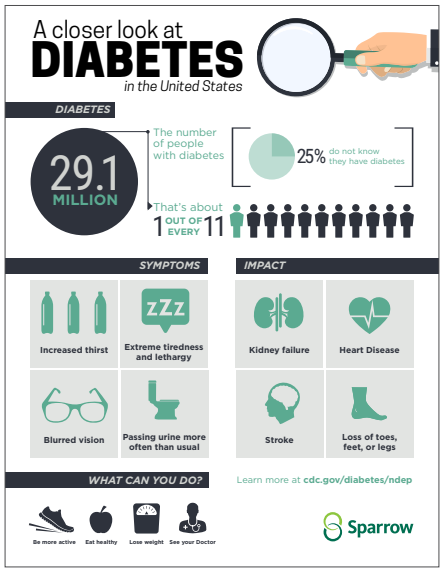
It is very easy to sign up for access to the portal. Visit **PHPMichigan.com/MyPHP** and select MyPHP Provider Portal. Once you are at the MyPHP Provider Portal, select proceed to our sign up process as shown below.

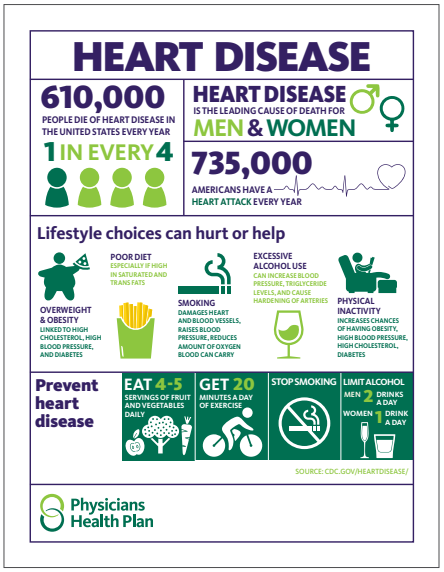


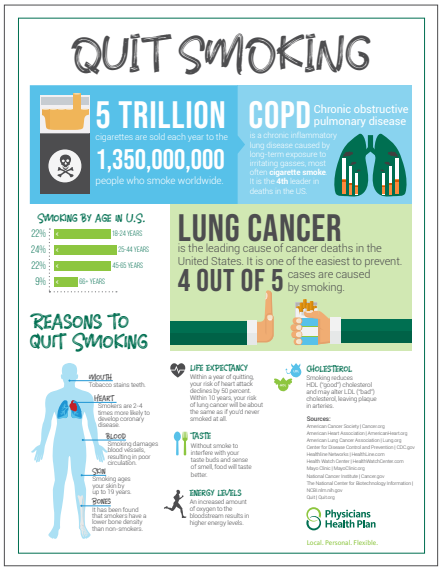
Infographics: Improving health literacy

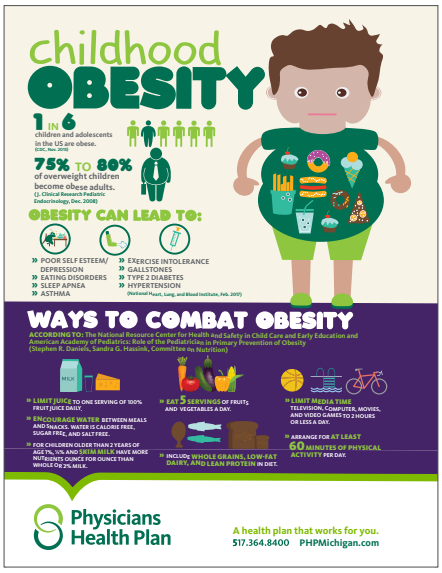
The use of infographics is not new and is increasingly used in healthcare to communicate key issues about common ailments that affect a sizable portion of the population, such as heart disease and obesity. Infographics are a useful tool for educating Members on seemingly complex health issues in a simple, easy-to-understand manner. The use of concise language and colorful design, including graphs and charts, is essential to attract a Member's attention and in relaying important health information. A firm grasp of health information helps Members make decisions and can improve their relationship with Providers, thus improving Member outcomes.

PHP is now producing a quarterly infographic surrounding various health and wellness campaigns to educate our Members and Providers. These infographics are available to Provider offices to distribute to Members, free of cost. Please email the Provider Relations Team to request a supply of these infographics, at **PHPProviderRelations@phpmm.org**. See below for currently available infographics:









Utilization Management news and updates

A comprehensive list of procedures and services requiring prior approval is available at **PHPMichigan.com/Providers**. Select "Notification and Prior Approval Table" to locate this list. This information is also avalible on the Provider portal, MyPHP.

If you have any questions about the prior approval process, please call the Customer Service Department at **517.364.8500** or **800.832.9168** during the hours of 8:30 a.m.to 5:30 p.m., Monday through Friday.

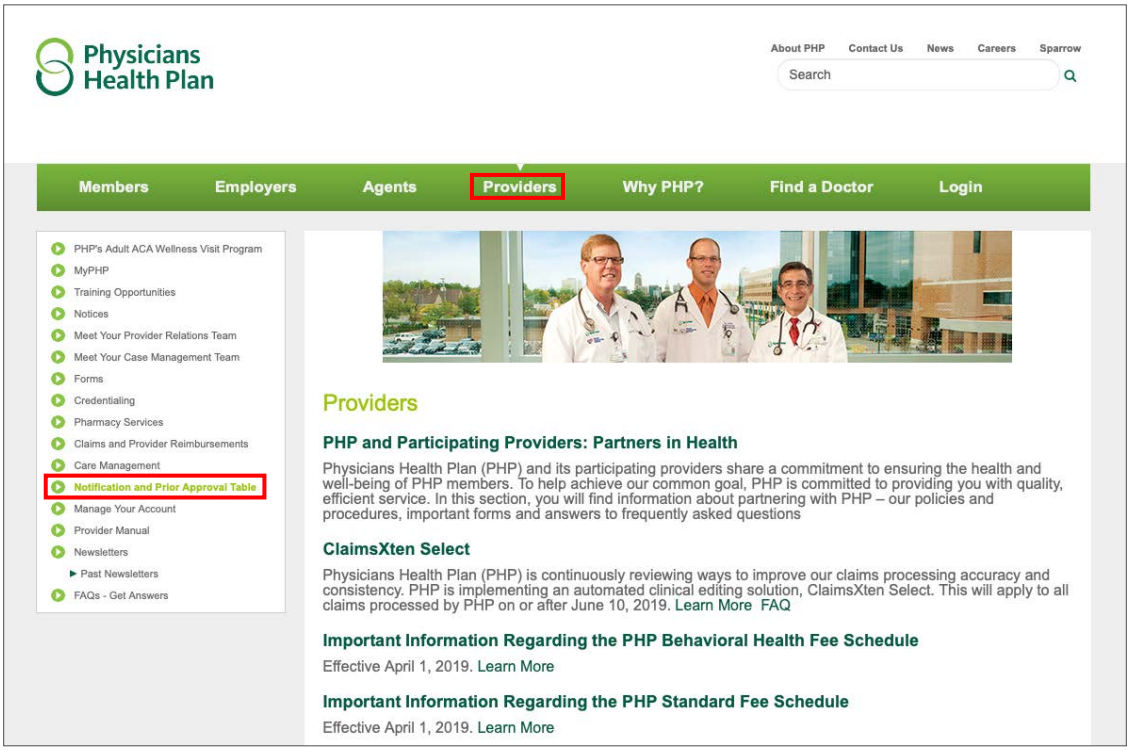
Reminder: Prior Approval requests may be submitted via the Utilization Management fax at **517.364.8409** from 8 a.m. to 5 p.m., Monday through Friday.

Changes to Coverage for Services

Code(s)	Procedure or Service	Action	Implementation Date
96116, 96121, 96132, 96133, 96136, 96137, 96138, 96139, 96146	Neurobehavioral status exam, Neuropsychological testing, Psychological or neuropsychological test administration	No Longer Requires Prior Approval	01/01/19
64612, 64615, 64616, 64642, 64643, 64644, 64645, 64646, 64647	Chemodenervation of muscles, Chemodenervation of extremity muscles	Requires Prior Approval (See Pharmacy policy: Botulinum Toxin A)	10/01/19
64650, 64653	Chemodenervation of eccrine glands... (treatment of hyperhidrosis)	Requires Prior Approval (See Pharmacy policy: Botulinum Toxin A)	10/01/19
E0163, E0165, E0168, E0167	Commode chair	Covered without Prior Approval	01/01/19
A4555	Electrode/ transducer for use with electrical stimulation device, used for cancer treatment, replacement only.	Requires Prior Approval	01/01/19
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type.	Requires Prior Approval	01/01/19

Notification/prior approval

Do you need to verify whether a service requires a prior approval? The best resource to verify this is on the PHP Notification/Prior Approval Table on our website or on the Provider Portal, MyPHP. Locate this table by going to **PHPMichigan.com** and selecting the Providers tab at the top of the screen. Once on the Providers tab, select Notification and Prior Approval Table on the left sidebar. The table gives you the most up-to-date list of services that require prior approval. If you have any questions, contact our Customer Service Department at **517.364.8500**.



Pharmacy news and updates

New medications formulary status	
Drug	**Formulary Action**
Motegrity (prucalopride succinate tablet)	Tier 3, Prior Approval Required
Ultomiris (ravulizumab IV solution)	Medical Prior Approval Required
Gamifant (emapalumab IV solution)	Medical Prior Approval Required
Elzonris (tagraxofusp IV solution)	Medical Prior Approval Required

Changes to the current formulary		
Drug	**Change made**	**Effective Date**
Hepatitis C Agents	Mayvret & sofosbuvir-velpatasvir are the preferred agents in this category	04/01/19
Minocycline Extended Release	Exclude extended release products. Formulary Alternative: immediate release minocycline	07/01/19
Cyclobenzaprine 7.5mg	Exclude 7.5mg only. Formulary Alternative: cyclobenzaprine 5mg & 10mg	07/01/19

Drug	**HCPS/CPT Code**	**Formulary Action**	**Effective Date**
Adenovirus Vaccine, Type 4, Live	90476	Exclude	06/01/19
Adenovirus Vaccine, Type 7, Live	90477	Exclude	06/01/19
Typhoid Vaccine- Vi Capsular Polysaccharide (ViCPs)	90691	Exclude	07/01/19

New Pharmacy HCPCS/CPT Codes			
Drug	**HCPS/CPT Code**	**Formulary Action**	**Effective Date**
Ajovy (fremanezumab-vfrm)	C9040	Pharmacy benefit only	04/01/19
Andexxa (coagulation Factor XA (recombinant), inactivated)	C9041	Exclude, inpatient use only	04/01/19
Belrapzo (bendamustine hcl)	C9042	Prior Approval required	04/01/19
Levoleucovorin Injection	C9043	Covered Code	04/01/19
Libtayo (cemiplimab-rwlc)	C9044	Prior Approval required	04/01/19
Lumoxiti (moxetumomab pasudotox-tdfk)	C9045	Prior Approval required	04/01/19
Cocaine hydrochloride nasal solution	C9046	Exclude, inpatient use only	04/01/19
Jivi (Factor VIII, (antihemophilic factor, recombinant) pegylated-aucl)	C9141	Prior Approval required	04/01/19

*Any Provider or Member that was directly impacted by these changes recieved a direct mailer explaining the changes. Letters can be located on **PHPMichigan.com**.

New specialty drug site-of-care policy

PHP encourages a strong relationship between our Members and Providers, while providing cost-effective care. As of July 1, 2019, to provide consistency and align with industry practices, PHP implemented new site-of-care requirements. The following list of medications require administration to occur in a non-facility setting, such as in your office or by a home infusion provider.

Medication brand names	Generic name	HCPCS codes
Benlysta	belimumab	J0490
Xgeva, Prolia	denosumab	J0897
Privigen, GamaSTAN, Cuvitru, Bivigam, Gammaplex, Hizentra, Gamunex-C, Gammaked, Carimune, Octagam, Gammagard, Flebogamma, Hyqvia, *others*	immune globulin	J1459, J1460, J1555, J1556, J1557, J1559, J1560, J1561, J1562, J1566, J1568, J1569, J1572, J1575, J1599
Simponi	golimumab	J1602
Remicade, Inflectra, Renflexis	infliximab	J1745, Q5103, Q5104
Xolair	omalizumab	J2357
Stelara	ustekinumab	J3357
Entyvio	vedolizumab	J3380

Site-of-care exceptions may be made when submitting a prior approval request. Prior approval of the medication is required before outpatient administration, regardless of the site of service. Members with an active approval are not subject to the program requirements until prior approval renewal on or after July 1, 2019. This program does not include oncology medications. This program does not apply to the self-funded SHS products (groups L0001269 or L0000264).

If you have questions regarding the PHP site-of-care policy, please visit our website at **PHPMichigan.com/Providers** or contact PHP Customer Service at **800.832.9186**.

CMS 1500 claim requirements

When filling out a PHP claim form, it is extremely important to complete all applicable boxes. PHP strives to have a high rate of Provider satisfaction related to claims processing. We want to make sure your claims are processed quickly. Simple errors can cause delay in claims payment and/or denials. One place to pay close attention is box 32. Filling out box 32 helps identify specific information regarding the service facility location. The EDI loop and segment is 2310C and 2420C*. When the service location differs from the billing location (i.e., box 33), box 32 is required to be filled out completely. Box 32 requires the following details:

Box 32 Service Facility Location Information (Required)

- Enter the Provider name.
- Enter the Provider address, without a comma between the city and state, and a nine-digit zip code without a hyphen.
- Enter the telephone number of the facility where services were rendered, if other than home or office.

Box 32a Service Facility Location Information (Required)

- For Service Facility Location Information ,-enter the NPI of the facility where the services were rendered.

Claim adjustments

At times it is necessary to adjust a claim. It is important to submit all claim adjustments via mail with the appropriate claim adjustment form. Claim adjustments should not be submitted electronically. Claim adjustment forms are located on the PHP website, **PHPMichigan.com**, located under the Provider's tab, then select Forms from the menu on the left. Please remember to fill out the form in its entirety and include a new UB04 or CMS 1500 claim form if changes are made to the original claim. All corrected claims must be received within the 180-day timely filing limits. Mail all corrected claims to:

Physician's Health Plan
PO Box 853936
Richardson, TX 75085-3936

Series billing requirements and reminders

When billing for a medical service, it is important to remember specific billing requirements, especially when billing for interim or series claims.

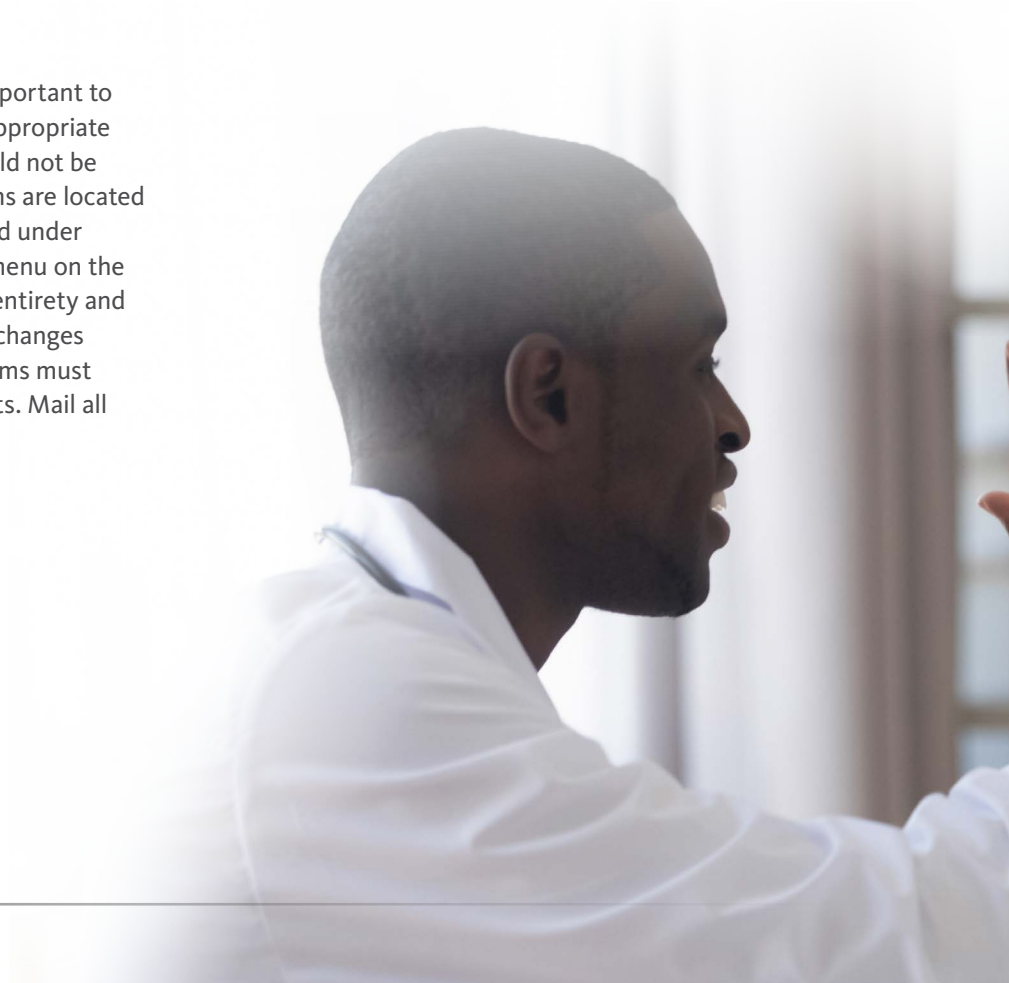
Use the accurate type of bill as required for each month's services with the accurate billing requirement for the initial, continuous, and discharge claim.

The guidelines for Interim and Series Billing are as follows

- Initial claim-xx2 type of bill
- Continuing Claims- xx3 type of bill
- Final/Discharge Claim- xx4 type of bill
- Final/Discharge Claims for Home Health-xx9 type of bill

Claims that are not submitted in this order will be rejected by PHP. If you have filed a recent claim and it was rejected, remember that a xx2 (first claim) must be on file and billed before any additional claims will be processed. In order to correct this, it is required to submit an adjustment claim. It is important to make sure the xx2 claim is on file before any additional bill types will be processed.

PHP greatly appreciates your cooperation as we strive for the highest level of quality related to claims submissions.



Global surgical package

Global Surgical Package includes pre-operative, intra-operative and post-operative services, dependent on the Global Period assigned to the CPT® code.

The global surgical period is dependent on the type of procedure or service reported. The Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule Relative Value File identifies the surgical period for each CPT®. Global surgical periods are categorized as follows

Minor Procedures

0-day

- No pre-operative or post-operative services included
- Visits/services beyond day of the procedure are separately billable

10-day

- No pre-operative period
- Day-of surgery
- 10-day post-operative period
- Total of 11 days

Major Procedures

90-day

- One-day pre-operative period visit performed day before surgery or day of surgery when the decision for surgery was already made at previous visit
- Day of surgery
- Ninety-day post-operative period
- Total of 92 days

Services that are separately billable and payable

- If the evaluation and decision for surgery occur the day prior to a major procedure a -57 modifier must be appended to the E/M code, which identifies it as a separate payable service from the global period
- If there is a significant, separately identifiable service an E/M is billable on the same day as a minor procedure and a 25 modifier must be appended to the E/M code
- **Transfer of care**: When the surgeon does not perform any portion of the post-operative care, an agreement to transfer of care can be made. This agreement would be made with a Physician outside of the same group practice and appropriate modifiers must be appended to the CPT® codes dependent on the scenario
- Diagnostic tests and procedures
- **Distinct surgical procedure during post-operative period**: This would include services that are not re-operations or treatment for complications
  - Appropriate modifier must be appended to the CPT® code
  - Documentation must support the appended modifier
- **Post-operative complications**: Treatment that requires a return to the operating room
  - Appropriate modifier must be appended to the CPT® code
  - Documentation must support the appended modifier
- This does not include minor treatment that can be provided at bedside or in the Physician office setting
- More extensive procedure required: If a less extensive procedure was tried initially and failed, the more extensive procedure is separately payable
- Immunosuppressive therapy for organ transplants
- Critical care services
  - The Patient must be critically ill and require constant attendance of the Physician
  - The critical care is above and beyond and usually unrelated to the anatomic injury or general surgical procedure

PHP's "Incident to" Billing Guidelines for Mid-Level Practitioners: Nurse Practitioners and Physician Assistants

PHP's "incident to" billing guidelines and protocols for Physicians and Non-Physician Practitioners should be followed to ensure appropriate documentation for reimbursement.

To qualify as "incident to," services must be part of a Patient's normal course of treatment, during which a MD/DO personally performs the initial service, determines the Plan of Care and remains actively involved. Subsequent services provided by the Mid-Level Provider must be related to the Plan of Care. Services provided by the mid-level Practitioner that qualify for "incident to billing" ,as defined, should be billed under the supervising Physician's NPI.

If there is a change in the Plan of Care, the service would no longer meet the requirement for "incident to" and the Patient must be re-evaluated by the MD/DO and services should be billed under the MD/DO's NPI number.

Signature Requirements

The supervising Physician is not required to co-sign the Patient's record when a PA/NP provides the service, however the supervising Physician must remain actively involved and documentation must support review and involvement in the oversight of the Patient's care.

For example, Patient's record must indicate that the supervising Physician reviewed and agreed with the course of treatment and/or diagnosis of an injury or illness.

Physician Assistants (PA)

PHP does not credential Physician Assistants. They are required to meet "incident to" billing guidelines in an office and outpatient setting. The services may be rendered by a PA and considered reimbursable as long as the following requirements are met.

- Supervising Physician does not have to be physically present in the Patient's Treatment room, but must be readily available to render assistance, if necessary
- Qualifying "incident to" services must be provided by a PA/NP whom the MD/DO directly supervises, and who represents a direct financial expense to the MD/DO's practice (such as a "W-2" or leased employee, or an independent contractor).
- For New Patients the Physician must personally review history, examine the Patient, and make medical decisions regarding the Patient's treatment and drug protocols.
- The PA must be licensed to render the services.
- PA must bill under supervising Physician's NPI number.

Nurse Practitioners (NP)

PHP does credential Nurse Practitioners. Any NP credentialed by PHP must bill their services under their own Provider NPI. Non-credentialed NPs must meet "incident to" billing guidelines in an office and outpatient setting. The services provided may be rendered by a NP and considered reimbursable as long as the following requirements are met.

- Supervising Physician does not have to be physically present in the Patient's treatment room, but must be readily available to render assistance, if necessary.
- Qualifying "incident to" services must be provided by a PA/NP whom the MD/DO directly supervises, and who represents a direct financial expense to the MD/DO's practice (such as a "W-2" or leased employee, or an independent contractor).
- For New Patients the Physician must personally review history, examine the Patient and make medical decisions regarding the Patient's treatment, and drug protocols.
- The NP must have a Master's Degree in nursing.
- The NP must be a registered professional nurse, authorized by the State in which their services are furnished to practice as a Nurse Practitioner, in accordance with state law.
- The NP must be certified as a Nurse Practitioner by the American Nurses Credentialing Center (ANCC) or other recognized national certifying entities that have established standards for nurse practitioners.
- Non-credentialed NPs must bill under supervising Physician's NPI number.
- Credentialed NPs must bill under their own NPI number.

Failure to comply with the above Physician Assistant and Nurse Practitioner guidelines may result in financial adjustments.

“Incident to” billing for behavioral health services

What is “incident to” billing?

- “Incident to” billing is the practice of billing medical services by one healthcare provider “incident to” another healthcare provider. “Incident to” a Physician’s professional services means the services are furnished as an integral, although incidental, part of the Physician’s personal professional services in the course of diagnosis of an injury or illness. It is permissible to bill under a Physician’s name when services provided by an APN/PA are “incident to” a Physician’s established plan of care.

Who is allowed to provide psychological services under the “incident to” provision?

- Doctorate or Master-level Clinical Psychologists
- Doctorate or Master-level Clinical Social Workers
- Clinical Nurse Specialists
- Nurse Practitioners

What are the supervisory requirements for “incident to”?

- The rendering Provider must be directly supervised by the billing Provider.
- Direct supervision means the billing Provider is within the same office as the rendering Provider.
- The supervising Provider must first evaluate the Patient personally and then initiate the course of treatment.

What information does a provider need to submit “incident to” on a claim?

- Supervising Physician’s NPI in 24J and signature in box 31 on the claim form.
- If a Provider is credentialed under their own NPI they are not eligible for “incident to” and are to bill under that NPI versus the supervising Physician.

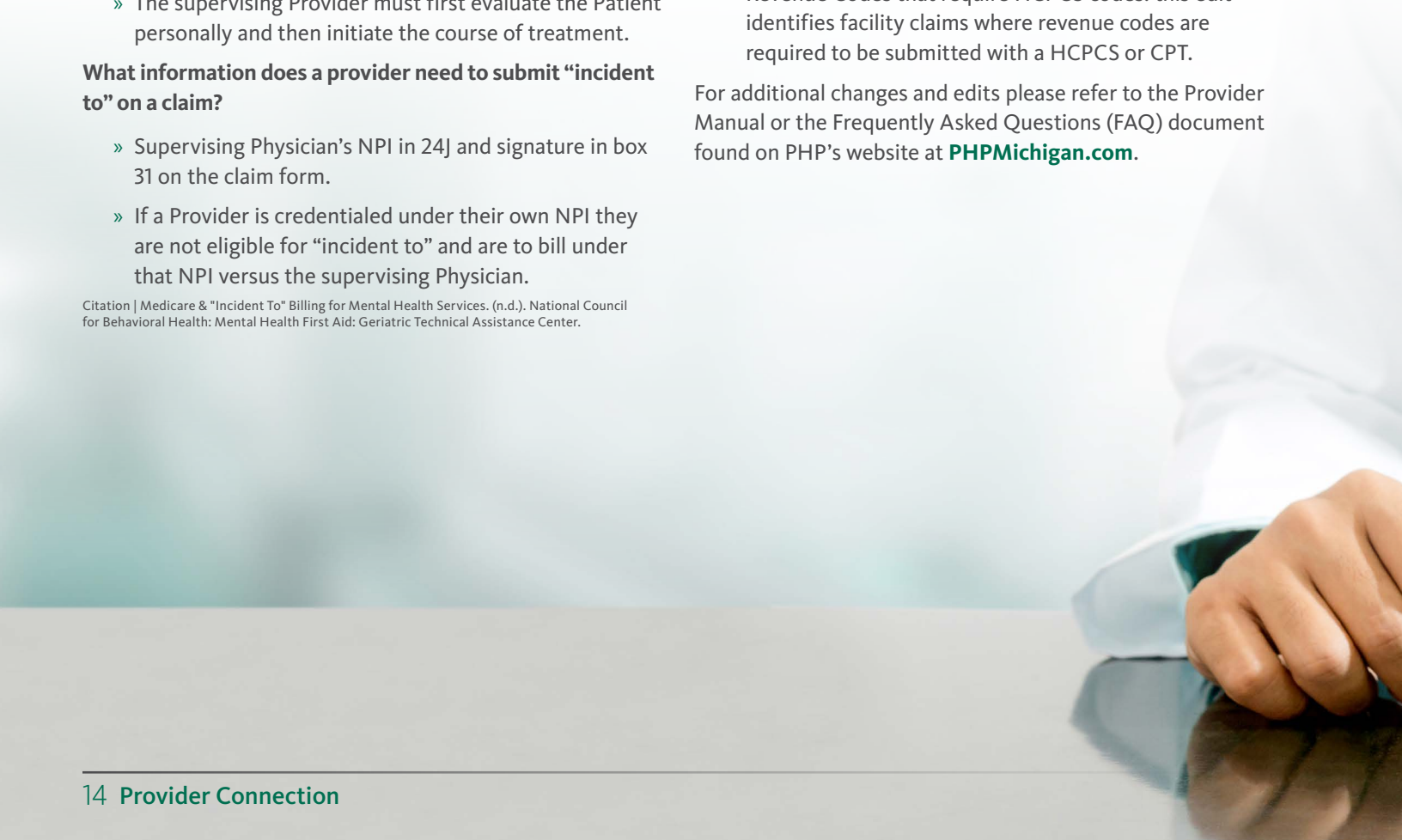
Citation | Medicare & "Incident To" Billing for Mental Health Services. (n.d.). National Council for Behavioral Health: Mental Health First Aid: Geriatric Technical Assistance Center.

Claim editing reminders

PHP uses Clinical Edits in the processing and payment of all claims. All Providers’ claims for payment are subject to PHP Clinical Edits. Clinical Edits focus upon correct coding methodologies and accurate adjudication of claims. PHP’s Clinical Edits follow general industry standards. Some specific edits to pay attention to are listed below:

- Medically Unlikely Edit (MUE) identifies claim lines where the MUE has been exceeded for a CPT/HCPCS code with MUE adjudication indicator (MAI) =1, 2 or 3, reported by the same Provider, same Member, and same date of service.
  - When a MUE has been exceeded the Providers’ Explanation of Payment (EOP) breaks out the lines.
  - First line has the approved units and any following lines are broken down into one unit per line for every denied unit billed.
  - For example, if the code has a MUE of 2 but 5 units are billed, line one processes for 2 units, lines 2, 3, and 4 are added with one unit each line and denied with code, “Denied procedure exceeds the MUE limit. Limit paid on different claim line.”
- Therapy reduction in a non-hospital setting: identifies claim lines that pay 100% of the procedure with the highest RVUs and reduces other therapies.
- Revenue Codes that require HCPCS codes: this edit identifies facility claims where revenue codes are required to be submitted with a HCPCS or CPT.

For additional changes and edits please refer to the Provider Manual or the Frequently Asked Questions (FAQ) document found on PHP’s website at **PHPMichigan.com**.



Importance of internal audits

PHP uses audits for our post-payment processing of medical claims. All Provider medical claims are subject to PHP auditing at any time. Audits focus on correct billing and coding methodologies. To help you understand some of the areas of focus, common reasons for denials found during the audit process are listed below.

Top reasons for Internal and External audit denials:

- Incorrect code selection
- Incorrect or missing modifiers
- Lack of supporting medical documentation
- Unbundling of services
- Undocumented start/stop times for time-based services

Internal billing and coding audits not only help safeguard practices when an external audit is completed, they contribute to a healthy and accurate Revenue Cycle Management process. The Office of Inspector General (OIG) has developed and published voluntary compliance program guidance for individual and small group practices published in the Federal Register (65 FR 36818).

Components of an Effective Compliance Program Include:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer and contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

You can obtain more information at **oig.hhs.gov/authorities/docs/physician.pdf**

Completing an annual review of your compliance and audit plans will help ensure best practices are in place. Some questions to keep in mind as you are building or updating these plans:

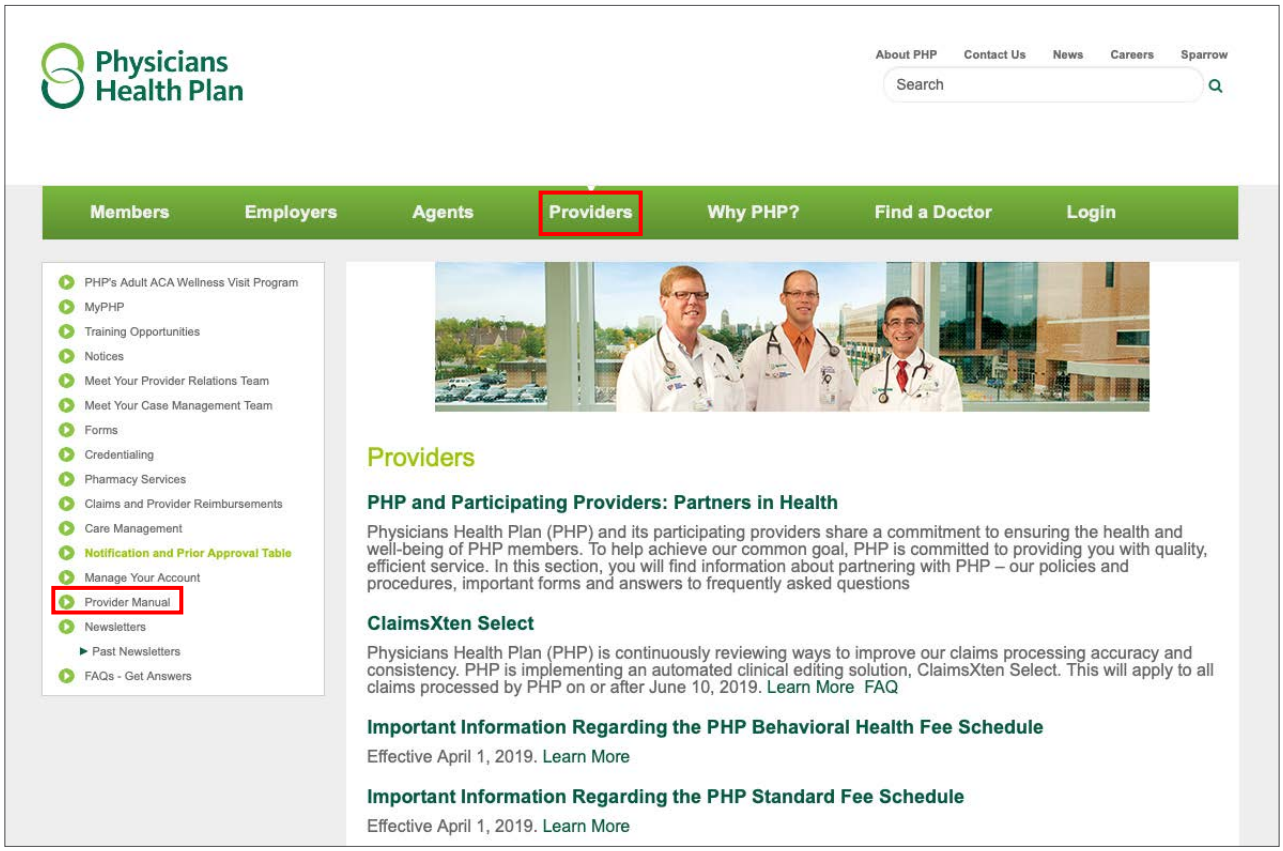
- Do you regularly audit a set percentage of claims based on the volume of your claim submissions?
- Do you have policies and procedures in place?
- Are you capturing all of the pertinent detail to support the services/procedures billed?
- Do you regularly review new codes/modifiers and identify those relevant to the practice to ensure updated chargemasters?
- Do you have a continuing education plan for coders on staff?
- Does your coding staff have coding and billing resources readily available?
- Are you reviewing denials in a timely manner and identify trends?
- Do you perform focused audits based on denial trends?
- Do you have claim and documentation request submission timelines in place?

Benefits of an Internal audit process:

- Identify areas of risk
- Improve Coding Accuracy
- Identify denial patterns
- Improved internal processes
- Increased timeliness and accuracy of payment
- Ensures staff is up to date on coding, billing, documentation, and timeline requirements
- Improves the appeal process, making it effortless, when and if claims are denied

Keeping up to date is important

Being informed regarding the most up-to-date standards and guidelines is essential to the success of any medical group, practice or facility. PHP provides the most up-to-date version of our Provider Manual on our website at **PHPMichigan.com** under the Provider page as shown below.



Third party billing inquiries

PHP is committed to ensuring the privacy of your information and the privacy of our Members. In order for PHP to release any Member specific information to an entity that your office has contracted with for the purposes of billing or account reconciliation, we need to know information about that company. PHP must receive written approval from the authorized individual in the Provider's practice to allow us to release this information to the company and their representatives.

Please be advised that if you employ an account reconciliation company that is primarily domiciled outside of the United States, Federal HIPAA laws prevent us from sharing Member-specific information, including specific claim and/or payment information.

The Provider's office must complete the medical release form included in this article and return it to PHP. The form is located on the PHP website, **PHPMichigan.com**, under the Provider tab and Forms. If we do not receive this information, verbal communication regarding our Members will not be given. If the company that your office partners with changes, please revise the form and send to PHP Customer Service Department via fax at **517.364.8411**. We require that the Physician or appropriate authorized person sign the designated medical release form.

BILLING COMPANY INFORMATION QUESTIONNAIRE

Please fill out the form in its entirety for PHP to release member information to your billing company. Please remember to revise the form with any updates including, but not limited to, a change in billing companies. Once the form is completed, please fax to:

If your account reconciliation company changes, please contact your PHP Customer Service Team.

We require that the practitioner(s) or appropriate designee sign the form.

1. Do you employ an account reconciliation company?	◯ **YES**. Proceed to #2.	◯ **NO**. Please sign, date, and return this questionnaire.
2. Name of the company		
3. Address of the company		
4. Company contact name		
5. Telephone number of contact		
6. List practitioners that are contracted with this company	Print Name	Signature

SIGNATURE REQUIRED

Print name of person completing this form (if other than the Physician)

Signature* Date

**By signing this form, you are giving permission to PHP to release Patient information to the above named company.*

Customer Service STAR Award Winner

Stacy Hall, April Winner

PHP Customer Service Department offers callers the opportunity to nominate a Customer Service Representative for the STAR Program. The STAR Program is a way to recognize outstanding customer service provided to you during your calls with PHP. At the end of every call, you have the opportunity to tell the representative you would like to nominate them for the STAR Program. Customer Service Leadership tallies the nominations and presents a certificate to the winner during a Customer Service Staff Meeting.

Stacy has been a member of the Customer Service team since November 2017. She participates in the event planning for the department, covers the front desk often and is always willing to work as late as needed. When asked what is your favorite part of working at PHP, Stacy replied "Being able to learn new things and speak to a variety of people daily." Stacy brings joy into her job every day by being outgoing and able to laugh at most situations. On a personal level, Stacy has an 11-year-old daughter who is in a national cheer squad. They have been lucky enough to be able to travel to Disney resorts through her cheering. Some of Stacy's hobbies include camping, riding dirt bikes, and spending time with her daughter.

Customer compliments of Stacy included: "You did a great job!" "You took a huge weight off my shoulders!" "PHP needs more employees like you!"

Stacy goes above and beyond to make every call successful. Remember that you can always nominate a staff member for the Customer Service STAR program. Thank you for assisting Stacy and our other Customer Service Representatives become STAR Caregivers.

Physicians Health Plan

1400 E. Michigan Avenue
P.O. Box 30377
Lansing, MI 48909-7877

Contact us

Department	Contact Purpose	Contact Number	Email Address
Customer Service	» To verify a covered person's eligibility, benefits, or to check claim status » To report suspected Member fraud and abuse » To obtain claims mailing address	517.364.8500 800.832.9186 (toll free) 517.364.8411 (fax)	
Medical Resource Management	» Prior authorization of procedures and services outlined in the Notification/Authorization Table » To request benefit determinations and clinical information » To obtain clinical decision-making criteria » Behavioral Health/Substance Use Disorders Services, for information on mental health and/or substance use disorders services including prior authorizations, case management, discharge planning, and referral assistance	517.364.8560 866.203.0618 (toll free) 517.364.8409 (fax)	
Network Services	» Credentialing - report changes in practice demographic information » Coding » Provider/Practitioner education » To report suspected Provider/Practitioner fraud and abuse » EDI claims questions » Initiate electronic claims submission	517.364.8312 800.562.6197 (toll free) 517.364.8412 (fax)	**Credentialing** PHP.Credentialing@phpmm.org **Provider Relations Team** PHPProviderRelations@phpmm.org
Pharmacy Services	» Request a copy of our Preferred Drug List » Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management	517.364.8545 877.205.2300 (toll free) 517.364.8413 (fax)	**Pharmacy** PHPPharmacy@phpmm.org
Quality Management	» Quality Improvement programs » HEDIS » CAHPS » URAC	517.364.8000 877.803.2551 (toll free) 517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
External Vendor	**Contact Purpose**	**Contact Number**	**Email Address**
Change Healthcare (TC3)	» When medical records are requested	**Mail To:** Change Healthcare 5755 Wayzata Blvd, St. Louis Park, MN 55416 952.949.3713 949.234.7603 (fax)	MedicalRecords@changehealthcare.com